emailed license Validation letter 1/31/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 1.17.12
Amount $1725.-
CK # 99005288

I. IDENTIFICATION

Name MOUNTAIN VIEW NURSING AND REHABILITATION CENTER

Address 39 FERNDALE APTS. ROAD

City/County/Zip PINEVILLE, KY 40977 Bell County

Telephone number 606-337-7071

Administrator KELLY GODDIN

Date facility operation began at current address 05-01-1987

Date facility began operation under current owner 01-01-2011

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	~~115~~	~~115~~
Nursing Home	~~115~~	~~115~~
Nursing Facility	115	115
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit ✓	Individual
County	Nonprofit	Partnership
City		Corporation ✓
Private ✓		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

HANGING ROCK, LTC, LLC

RECEIVED
JAN 17 2012
1/31
OFFICE OF INSPECTOR GENERAL

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of Corporation Hanging Rock, LTC, LLC

Address of corporation P.O. Box 6249 Kinston, NC

President or Chairman N. Randy Uzzell

Vice President Raymond J. Baker

Secretary Raymond J. Baker

Treasurer Dianne Johnson

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Kelly Gradin by proxy Admin 1/24/12

Signature of authorized representative by permission Title Date

Return Application and fee to : Office of Inspector General
275 East Main Street, 5E-A
Frankfort, KY 40621